Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

KIRT REPP DC
PO BOX 9973
THE WOODLANDS TX 77387-6973

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box
Box Number 45

MFDR Tracking Number
M4-12-2701-01

MFDR Date Received
April 20, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…I would like to point out that the ODG chapter that was referenced in our materials was the 'Pain" [sic] chapter. That was because the patient met the exact definition of 'Chronic Pain' as per the same ODG 'Pain' chapter definition as a direct result of the compensable work-related injuries. The ODG 'Pain' chapter 'Recommends' both 'EMG' and 'NCS'."

Amount in Dispute: $1,180.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Review of the ODG under the diagnosis utilized by the provider which is 847.2-Sprain lumbar region indicates for F-Wave test is not recommended and to see EMGs."

Response Submitted by: State Office of Risk Management, PO Box 13777, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 21, 2011	CPT Code 95903	$1,180.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the procedures for obtaining preauthorization.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Payment denied/reduced for absence of precertification/preauthorization.
   - 17 – Payment adjusted because requested information was not provided or was insufficient/incomplete.
   - F-Wave test are not recommended for DX per ODG. Per Rule 134.600(p) carrier is not liable for treatment

and/or services provided in excess of the Divisions Treatment Guidelines unless in emergency or pre-authorization rules.

Issues

1. Did the treatment/service in dispute require preauthorization?
2. Is the requestor entitled to reimbursement?

Findings

1. In accordance with 28 Texas Administrative Code §134.600(p) Non-emergency health care requiring preauthorization includes: (12) treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier. Review of the ODG for procedures allowed for diagnoses code 847.2 finds that CPT Code 95903 is not one of the codes listed. Therefore, preauthorization is required.
2. Review of the submitted documentation finds that reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 23, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.